Kansas Medical Assistance Program
PA Phone 800-933-6593
PA Fax 800-913-2229

Aetna Better Health of KS
PA Pharmacy Phone 855-221-5656
PA Pharmacy Fax 844-807-8453
PA Medical Phone 855-221-5656
PA Medical Fax 855-225-4102

Sunflower
PA Pharmacy Phone 877-397-9526
PA Pharmacy Fax 866-399-0929
PA Medical Phone 877-644-4623
PA Medical Fax 888-453-4756

UnitedHealthcare
PA Pharmacy Phone 800-310-6826
PA Pharmacy Fax 866-940-7328
PA Medical Phone 866-604-3267
PA Medical Fax 866-943-6474

Spinal Muscular Atrophy (SMA) Agents PRIOR AUTHORIZATION FORM

Complete form in its entirety and fax to the appropriate plan's PA department.
For questions, please call the pharmacy helpdesk specific to the member's plan.

CHECK ONE: ☐ **Drug dispensed from a pharmacy (pharmacy benefit)**
☐ **Drug administered in an office or outpatient setting (medical benefit)**

MEMBER INFORMATION		
Name:	Medicaid ID:	
Date of Birth:	Gender:	
PRESCRIBER INFORMATION		
Name:	Medicaid ID:	
NPI:	Phone:	Fax:
Address:	City, State, Zip Code:	

The following medications require Prior Authorization (PA). Medications requiring PA may have to meet clinical **and** Non-Preferred PA criteria before the claim may be considered for payment.

Please provide the required data for the specific drug being requested. Below is a list of links you may find helpful in determining the required information:

- Clinical PA criteria: http://www.kdheks.gov/hcf/pharmacy/pa_criteria.htm
- KS Preferred Drug List (PDL): http://www.kdheks.gov/hcf/pharmacy/download/PDLList.pdf
- Non-Preferred, PA Required PDL criteria: http://www.kdheks.gov/hcf/pharmacy/download/NonPreferred_PA_Criteria_for_PDL_Drugs.pdf
- KS NDC lookup tool: https://www.kmap-state-ks.us/Provider/PRICING/NDCSearch.asp
- KS HCPCS lookup tool: https://www.kmap-state-ks.us/Provider/PRICING/HCPCSSearch.asp

Note: Any area not filled out will be considered not applicable to this PA & may affect the outcome of this request.

Instructions to complete this form:
1. Complete **the Member/Prescriber Information** portion above and **Section I** for **ALL** requests.
2. **Complete the appropriate subsections of Section II for all clinical information required.**
3. Complete **Section III only,** if the requested medication is a renewal.
4. Prescriber - **Sign and date** the form prior to submission.

SECTION I: MEDICATION REQUESTED

Select the appropriate medication(s) for this request:
☐ Nusinersen (Spinraza®) – Complete Section II-A OR Section III
☐ Onasemnogene (Zolgensma®) – Complete Section II-B

NDC/HCPCS (J Code)	Strength	Dosage Form	Quantity	Directions for Use

Indication/Diagnosis:

Is the requested medication being prescribed for an FDA-approved indication? ☐ YES ☐ NO
Indication: _____
ICD-10: _____
Patient's weight: _____ ☐ lbs. ☐ kg

Providers: You are required to return, destroy or further protect any PHI received on this document pertaining to members whom you are not currently treating. Providers are required to immediately destroy any such PHI or safeguard the PHI for as long it is retained. In no event are you permitted to use or re-disclose such PHI.

PATIENT NAME:		MEDICAID ID:	

SECTION II-A: CLINICAL INFORMATION – NUSINERSEN (SPINRAZA®)

1. **Is this a new or renewal request for this medication?**
   □ New □ Renewal – Proceed to Section III.
2. **Please document the prescribing physician's specialty.**
   □ Neurologist- (with expertise in SMA) □ Other
   A. **If <u>other</u>, has the prescribing provider consulted with one of the provider specialties listed above in question 2?**
      □ YES – **If <u>YES</u>, please document the provider's name, specialty and date of consult:**
      Provider name: _____ Specialty: _____ Date of Consult: _____
      □ NO
3. **Please provide the baseline of one of the following metrics:**

Metric/Scoring Tool	Value (Include Units if Applicable)
HINE (Hammersmith Infant Neurological Exam) score	
HFMSE (Hammersmith Functional Motor Scale Expanded) score	
ULM (Upper Limb Module) test score (Non-ambulatory) OR RULM (Revised Upper Limb Module) test score	
CHOP-INTEND (Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders) score	

4. **Please provide all of the following information:**

- Summary of the genetic testing results that confirmed spinal muscular atrophy:

_____
_____
_____
_____
_____

- The number of copies of the SMN2 gene:

Copies: _____

- The name(s) of the healthcare professional(s) experienced in lumbar punctures who is/are administering (or directing the administration) of nusinersen:

_____
_____

- For patients that have previously received onasemnogene, explain the rationale for using nusinersen:

_____
_____
_____
_____

- Description of the patient's ventilation status (including, but not limited to: the reason for ventilation, the extent of ventilation, and the amount of ventilation required):

_____
_____
_____
_____
_____
_____

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PATIENT NAME:		MEDICAID ID:	

SECTION II-B : CLINICAL INFORMATION – ONASEMNOGENE (ZOLGENSMA®)

1. **Is this a new request for this medication?**
   □ New (Renewal not allowed for Onasemiogene (Zolgensma®))
2. **Please document the prescribing physician's specialty.**
   □ Neurologist- (with expertise in SMA) □ Other

   A. **If <u>other</u>, has the prescribing provider consulted with one of the provider specialties listed above in question 2?**
      □ YES – **If <u>YES</u>, please document the provider's name, specialty and date of consult:**
      Provider name: _____ Specialty: _____ Date of Consult: _____
      □ NO

3. **Please provide the baseline of one of the following metrics:**

Metric/Scoring Tool	Value (Include Units if Applicable)
HINE (Hammersmith Infant Neurological Exam) score	
CHOP-INTEND (Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders) score	

4. **Please provide all of the following information:**

- Summary of the genetic testing results that confirmed spinal muscular atrophy:

_____

_____

_____

_____

_____

- The date that the patient initially had symptoms:
  Date: _____
- For prematurely born patients, the date that the patient reached the corresponding full gestational age:
  Date: _____
- If replacing nusinersen, the date that nusinersen is documented to be discontinued:
  Date: _____
- ELISA binding immunoassay - Anti-AAV9 Antibody titers:
  Titer: _____
- Description of how advanced the patient's SMA is:

_____

_____

_____

_____

- Description of the patient's ventilation status (including, but not limited to: the reason for ventilation, the extent of ventilation, and the amount of ventilation required):

_____

_____

_____

_____

_____

_____

- Patient's calculated dose:

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PATIENT NAME:		MEDICAID ID:	

SECTION III: RENEWAL - NUSINERSEN (SPINRAZA®) ONLY.

1. Does the prescriber attest that the patient has received clinical benefit from continuous treatment with the requested medication?
   ☐ YES ☐ NO

2. Please provide the most recent value for the same metric/scoring tool selected in Section II in original PA request.

   Metric/Scoring Tool: _____

   Value (Include Units if Applicable): _____

   Date: _____

3. Describe the effect(s) of the requested medication on the patient with regards to spinal muscular atrophy:

   _____
   _____
   _____
   _____
   _____
   _____
   _____

4. Please provide all of the following information:

   - The name(s) of the healthcare professional(s) experienced in lumbar punctures who is/are administering (or directing the administration) of nusinersen:

   _____
   _____
   _____

   - For patients that have previously received onasemnogene, explain the rationale for using nusinersen:

   _____
   _____
   _____
   _____

   - Description of the patient's ventilation status (including, but not limited to: the reason for ventilation, the extent of ventilation, and the amount of ventilation required):

   _____
   _____
   _____
   _____
   _____
   _____

PRESCRIBER SIGNATURE

☐ **I have completed all applicable boxes and attached any required documentation for review, in addition to signing and dating this form.**

_____ _____

Prescriber or authorized signature **Date**

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

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